

		FOR OHF USE					

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**2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0036202</u> Facility Name: <u>Manorcare Health Services Homewood</u> Address: <u>'940 Maple Avenue</u> <u>Homewood</u> <u>60430</u> <div style="display: flex; justify-content: space-between; width: 100%;"> Number City Zip Code </div> County: <u>Cook</u> Telephone Number: <u>'(708) 799-0244</u> Fax # <u>'(708) 799-1505</u> IDPA ID Number: <u>'34-4420510</u> Date of Initial License for Current Owners: <u>'06/18/90</u> Type of Ownership: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </div> <div> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </div> <div> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </div> </div>	
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In the event there are further questions about this report, please contact:
Name Gary Geise **Telephone Number** (708) 252-5731

Facility Name & ID Number Manorcare Health Services Homewood# 0036202Report Period Beginning: 01/01/00Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,920</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,920</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF		<u>1,988</u>	<u>11,023</u>	<u>13,011</u>	8
9	SNF/PED					9
10	ICF	<u>9,945</u>	<u>10,060</u>	<u>1,041</u>	<u>21,046</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,945</u>	<u>12,048</u>	<u>12,064</u>	<u>34,057</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 77.54%)

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 06/18/90

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 06/18/90 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 47 and days of care provided 8,932Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Manorcare Health Services Homewood # 0036202 Report Period Beginning: 01/01/00 Ending: 12/31/00
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	183,905	19,021	5,664	208,590	1,736	210,326	0	210,326		1
2	Food Purchase		160,916		160,916		160,916	(148)	160,768		2
3	Housekeeping	106,572	15,821	145	122,538		122,538	0	122,538		3
4	Laundry	25,910	8,455	240	34,605		34,605	0	34,605		4
5	Heat and Other Utilities			111,332	111,332	7,959	119,291	0	119,291		5
6	Maintenance	24,037	14,363	60,539	98,939		98,939	0	98,939		6
7	Other (specify): Medical Waste			3,889	3,889		3,889	0	3,889		7
8	TOTAL General Services	340,424	218,576	181,809	740,809	9,695	750,504	(148)	750,356		8
	B. Health Care and Programs										
9	Medical Director			17,250	17,250		17,250	0	17,250		9
10	Nursing and Medical Records	1,355,056	168,207	47,691	1,570,954	31,457	1,602,411	0	1,602,411		10
10a	Therapy	331,018	2,170	74,048	407,236		407,236	0	407,236		10a
11	Activities	55,455	796	724	56,975		56,975	0	56,975		11
12	Social Services	82,067			82,067		82,067	0	82,067		12
13	Nurse Aide Training							0			13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	1,823,596	171,173	139,713	2,134,482	31,457	2,165,939		2,165,939		16
	C. General Administration										
17	Administrative	50,305		347,841	398,146	(65,674)	332,472	0	332,472		17
18	Directors Fees							0			18
19	Professional Services			18,551	18,551	(18,551)		0			19
20	Dues, Fees, Subscriptions & Promotions			50,498	50,498		50,498	(29,616)	20,882		20
21	Clerical & General Office Expense	165,400	33,196	107,952	306,548		306,548	(66,336)	240,212		21
22	Employee Benefits & Payroll Taxes			527,214	527,214		527,214	0	527,214		22
23	Inservice Training & Education			656	656		656	0	656		23
24	Travel and Seminar			11,259	11,259		11,259	0	11,259		24
25	Other Admin. Staff Transportation							0			25
26	Insurance-Prop.Liab.Malpractice			44,476	44,476		44,476	0	44,476		26
27	Other (specify): Person Purchases							(13)	(13)		27
28	TOTAL General Administration	215,705	33,196	1,108,447	1,357,348	(84,225)	1,273,123	(95,965)	1,177,158		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,379,725	422,945	1,429,969	4,232,639	(43,073)	4,189,566	(96,113)	4,093,453		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Manorcare Health Services Homewood # 0036202 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			317,218	317,218	43,073	360,291	0	360,291		30
31	Amortization of Pre-Op. & Org.							0			31
32	Interest			90,469	90,469		90,469	0	90,469		32
33	Real Estate Taxes			294,859	294,859		294,859	0	294,859		33
34	Rent-Facility & Grounds							0			34
35	Rent-Equipment & Vehicles			32,378	32,378		32,378	0	32,378		35
36	Other (specify):*							0			36
37	TOTAL Ownership			734,924	734,924	43,073	777,997		777,997		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers		449,437	16,034	465,471		465,471	0	465,471		39
40	Barber and Beauty Shops		276	8,556	8,832		8,832	0	8,832		40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			65,880	65,880		65,880	0	65,880		42
43	Other (specify):* IV Drugs		119,372		119,372		119,372	0	119,372		43
44	TOTAL Special Cost Centers		569,085	90,470	659,555		659,555		659,555		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,379,725	992,030	2,255,363	5,627,118	0	5,627,118	(96,113)	5,531,005		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Manorcare Health Services Homewood

0036202

Report Period Beginning: 01/01/00

Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals	(148)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,025)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(13)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(62,113)	21		24
25	Fund Raising, Advertising and Promotional	(29,616)	20		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	Nurse Aide Training for Non-Employees				28
29	Yellow Page Advertising				29
29	Other-Attach Schedule <u>Vending Inc. & Misc.</u>	(2,198)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (96,113)		\$	30

OHF USE ONLY

48		49		50		51		52	
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B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (96,113)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport		x	\$	38
39					39
40	Gift and Coffee Shops		x		40
41	Barber and Beauty Shops		x		41
42	Laboratory and Radiology		x		42
43	Prescription Drugs		x		43
44	Exceptional Care Program		x		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb Manorcare Health Services Homewood

0036202 Report Period Beginning:

01/01/00

Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
A

Operating Expenses		PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0 1
2	Food Purchase	(148)	0	0	0	0	0	0	0	0	0	0	(148) 2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0 3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0 5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0 6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8	TOTAL General Services	(148)	0	0	0	0	0	0	0	0	0	0	(148) 8
B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0 10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0 11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0 12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0 13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0 14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 15
16	TOTAL Health Care and Program	0	0	0	0	0	0	0	0	0	0	0	0 16
C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0 19
20	Fees, Subscriptions & Promotions	(29,616)	0	0	0	0	0	0	0	0	0	0	(29,616) 20
21	Clerical & General Office Expenses	(64,138)	0	0	0	0	0	0	0	0	0	0	(64,138) 21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0 22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0 23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0 24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0 25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0 26
27	Other (specify):*	(13)	0	0	0	0	0	0	0	0	0	0	(13) 27
28	TOTAL General Administration	(93,767)	0	0	0	0	0	0	0	0	0	0	(93,767) 28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(93,915)	0	0	0	0	0	0	0	0	0	0	(93,915) 29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number: Manorcare Health Services Homewood

0036202

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(93,915)	0	0	0	0	0	0	0	0	0	0	(93,915)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Show Pgs 6A thru 6B
Show Pgs 6E thru 6I
Hide Pgs 6A thru 6I

[illegible]

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

Part 1: Information to be disclosed for relationships with related parties as specified for Part 1 of Form 277E				Part 2: Information to be disclosed for relationships with related parties as specified for Part 2 of Form 277E			
Schedule	Line	Item	Amount	C. Cost to Related Organization		D. Difference	
				Name of Related Organization	Percentage of Ownership (as Determinable)	Operating Cost of Related Organization	Adjustment to Operating Costs of Related Organization (Costs of Related Parties)
F	1	Office Office Supplies	747,881	HC W. Watson, Inc.	100.00%	747,881	-
F	2	Office Office Supplies					-
F	3	Office Office Supplies					-
F	4	Office Office Supplies					-
F	5	Office Office Supplies					-
F	6	Office Office Supplies					-
F	7	Office Office Supplies					-
F	8	Office Office Supplies					-
F	9	Office Office Supplies					-
F	10	Office Office Supplies					-
F	11	Office Office Supplies					-
F	12	Office Office Supplies					-
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F	61	Office Office Supplies					-
F	62	Office Office Supplies					-
F	63	Office Office Supplies					-
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F	265	Office Office Supplies					-
F	266	Office Office Supplies					-
F	267	Office Office Supplies					

Sum_6

* Total must agree with the amount entered on line 24 of Schedule V
DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number.
5. The adjustments entered on this page will automatically transfer to the summary pages.

[illegible]

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. **THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI**

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
**FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME
 ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Print Preview

| the name(s)
PORTS.

Facility Name & ID Number Manorcare Health Services Homewood# 0036202 Report Period Beginning: 01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D

Show Pgs 8E thru 8I

Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HCR ManorCare, Inc.Street Address 333 N. Summit St.City / State / Zip Code Toledo, OH 43604-2617Phone Number (419) 252-5500Fax Number (419) 254-5495

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	#####	357 Nurs.Fac.	\$ 0	\$ 5,346,945	\$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	#####	357 Nurs.Fac.	671,002	407,536	5,346,945	1,736
3	5	Utilities - Direct	Accumulated Cost	#####	357 Nurs.Fac.	262,823		5,346,945	774
4	5	Utilities - Pooled	Accumulated Cost	#####	357 Nurs.Fac.	2,777,349		5,346,945	7,185
5	10	Nursing - Direct	Accumulated Cost	#####	357 Nurs.Fac.	6,096,791	4,282,378	5,346,945	17,948
6	10	Nursing - Pooled	Accumulated Cost	#####	357 Nurs.Fac.	5,221,432	3,383,186	5,346,945	13,509
7	17	General & Admin - Direct	Accumulated Cost	#####	357 Nurs.Fac.	23,025,730	19,694,773	5,346,945	67,784
8	17	General & Admin - Pooled	Accumulated Cost	#####	357 Nurs.Fac.	82,128,599	31,955,235	5,346,945	212,480
9	22	Employee Benefits - Direct	Accumulated Cost	#####	357 Nurs.Fac.	2,724,065		5,346,945	8,019
10	22	Employee Benefits Pooled	Accumulated Cost	#####	357 Nurs.Fac.	(9,534,453)		5,346,945	(24,667)
11	30	Depreciation - Direct	Accumulated Cost	#####	357 Nurs.Fac.	74,480		5,346,945	219
12	30	Depreciation - Pooled	Accumulated Cost	#####	357 Nurs.Fac.	16,563,680		5,346,945	42,854
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 130,011,498	\$ 59,723,108		\$ 347,841

Print Preview

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bank of America		X	Finance Capital Additions	N/A		\$ 1,104,955	\$ 1,104,955	N/A		\$ 84,615	1	
2	Bank of America		X	Finance Capital Additions	N/A		78,359	78,359	N/A		5,979	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8	Interest Income										(125)	8	
9	TOTAL Facility Related						\$ 1,183,314	\$ 1,183,314			\$ 90,469	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,183,314	\$ 1,183,314			\$ 90,469	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Print Preview

Facility Name & ID Number **Manorcare Health Services Homewood**# **0036202**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	291,678	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	293,585	2
3. Under or (over) accrual (line 2 minus line 1).	\$	1,907	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	293,585	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	315	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND <u>948</u> For <u>19 94</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	(948)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	294,859	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	279,445	8
	1996	276,226	9
	1997	283,749	10
	1998	291,678	11
	1999	285,420	12

FOR OFF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATIO	\$	16

Line 2 = \$145,839 + \$147,746 for 1999

Line 4 = Total tax per "2000 First Installment Real Estate Tax Bill".

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,083 B. General Construction Type: Exterior Masonry Frame Wood Number of Stories 3

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1990	\$ 383,373	1
2					2
3	TOTALS			\$ 383,373	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B

Show Pgs 12C and 12D

Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Manorcare Health Services Homewood

0036202

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1990	1990	\$ 2,845,250	\$ 71,217	40	\$ 71,217	\$	\$ 747,775	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Land Improvement (Current Year Depreciation)					130,626		130,626		810,384	9
10	Land Improvement			1990	429,835						10
11	Building Improvement			1990	65,079						11
12	Land Improvement			1991	1,679						12
13	Building Improvement			1991	4,525						13
14	Land Improvement			1992	565						14
15	Building Improvement			1992	1,403						15
16	Land Improvement			1993	5,108						16
17	Building Improvement			1993	136,058						17
18	Land Improvement			1994	13,285						18
19	Building Improvement			1994	68,753						19
20	Land Improvement			1995	5,027						20
21	Building Improvement			1995	432,505						21
22	Land Improvement: Concrete, Landscaping, Fence			1996	20,361						22
23	Bdlg. Improvement: Renovation and Therapy Addition			1996	272,989						23
24	Building Improvements: Ceilings			1996	32,086						24
25	Building Improvements: Sprinkler System			1996	27,570						25
26	Building Improvements: Electrical			1996	60,701						26
27	Bdlg. Improvements: Painting, Wallcovering, carpet, cable wirin			1996	113,866						27
28	Land Improvement: Fence, Courtyard, Landscaping			1997	8,235						28
29	Bdlg Improvements: Wallcovering, Painting, VWC from Invento			1997	21,646						29
30	Building Improvements: engineering fees, doors, electrical wiring			1997	48,562						30
31	gazebo, egress system, insulation, dementia unit, alzheimer add.										31
32	Land Improvement; asphalt parking lot			1998	20,770						32
33	Bdlg. Improvements; custom cabinets; electrical work, water hea			1998	35,818						33
34	Bdlg. Improvements: wallcoverings, carpet, painting			1998	44,883						34
35											
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 201,843		\$ 201,843	\$	\$ 1,558,159	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Page 12A

Facility Name & ID Numbe Manorcare Health Services Homewood

0036202

Report Period Beginning:

01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	(2) Nurses Stations		1999		8,850						9
10	Carpet		1999		1,882						10
11	Flooring		1999		325						11
12	Plumbing		1999		3,750						12
13	Alzh Remodel		1999		1,050						13
14	Security System		1999		1,626						14
15	Corner Guards		1999		307						15
16	Building Improvements		1999		4,536						16
17	Add'l cost for Nurses Stnt		1999		552						17
18	Carpet		1999		1,012						18
19	Furnaces (2) & Thermostats (5)		1999		7,350						19
20	Wallcovering, Paper, Paint, & Corner Guards		2000		34,575						20
21	Carpet		2000		8,718						21
22	Signs		2000		639						22
23	Sign		2000		1,385						23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
					\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Page 12B

Facility Name & ID Numbe Manorcare Health Services Homewood

0036202

Report Period Beginning:

01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

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Facility Name & ID Number Manorcare Health Services Homewood

0036202

Report Period Beginning:

01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Facility Name & ID Numbe Manorcare Health Services Homewood

0036202

Report Period Beginning:

01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number Manorcare Health Services Homewood# 0036202

Report Period Beginning:

01/01/00

Ending:

12/31/00**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 1,400,331	\$ 115,375	\$ 115,375	\$		\$ 963,209	37
38	Current Year Purchases	55,409						38
39	Fully Depreciated Assets							39
40	Home Office Allocation		43,073	43,073				40
41	TOTALS	\$ 1,455,740	\$ 158,448	\$ 158,448	\$		\$ 963,209	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 360,291	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 360,291	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 2,521,368	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease **N/A**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipm: \$ **32,378** Description: **02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, etc.**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Transportatio	1992 Ford Supreme B	\$ 36.00	\$ 1,995	17
18				Above figure include	18
19				gas & maintenance	19
20					20
21	TOTAL		\$ 36.00	\$ 1,995	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2001 \$ _____

13. _____/2002 \$ _____

14. _____/2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number Manorcare Health Services Homewood

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0036202Report Period Beginning: 01/01/00 Ending: 12/31/00**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)****A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES☒ NOIf "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.2. CLASSROOM PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐COMMUNITY COLLEGE ☐

HOURS PER AIDE _____

3. CLINICAL PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐

HOURS PER AIDE _____

B. EXPENSES**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOMEIn the box below record the amount of income your
facility received training aides from other facilities\$ **D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number Manorcare Health Services Homewood# 0036202

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4		5	6	7	8				
	Service	Schedule V Line & Column Reference	Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)				
							Units	Cost							
1	Licensed Occupational Therapist	10a	4,203	hrs	\$	102,800		\$	617	4,203	\$	103,417	1		
2	Licensed Speech and Language Development Therapist	10a	3,488	hrs		95,222	59		14,345	385	3,547	109,952	2		
3	Licensed Recreational Therapist			hrs									3		
4	Licensed Physical Therapist	10a	2,573	hrs		65,415			617	2,573		66,032	4		
5	Physician Care			visits									5		
6	Dental Care			visits									6		
7	Work Related Program			hrs									7		
8	Habilitation			hrs									8		
9	Pharmacy	39,2		# of prescripts					448,490			448,490	9		
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs									10		
11	Academic Education			hrs									11		
12	Exceptional Care Program												12		
13	Other (specify): X-Ray & Lab	39,3							10,660			10,660	13		
14	TOTAL				\$	263,437	59	\$	25,005	\$	450,109	10,323	\$	738,551	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number Manorcare Health Services Homewood

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Report Period Beginning: 01/01/00

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XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (40,404)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 334,270)	1,654,301		3
4	Supply Inventory (priced at)	19,072		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	(9,930)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,623,039	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	383,373		13
14	Buildings, at Historical Cost	4,793,116		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,455,740		16
17	Accumulated Depreciation (book methods)	(2,521,368)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	9,930		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,120,791	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,743,830	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 75,311	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	207,788		30
31	Accrued Taxes Payable (excluding real estate taxes)	44		31
32	Accrued Real Estate Taxes(Sch.IX-B)	293,585		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Trade Payables & Liabilities	40,786		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 617,514	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,183,314		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,183,314	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,800,828	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,943,002	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,743,830	\$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,556,927	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,556,927	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	755,748	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 755,748	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(369,673)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (369,673)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,943,002	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number Manorcare Health Services Homewood

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Report Period Beginning: 01/01/00

Ending:

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,151,922	1
2	Discounts and Allowances for all Levels	(402,687)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,749,235	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,132,855	6
7	Oxygen	72	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,132,927	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,191	12
13	Barber and Beauty Care	8,662	13
14	Non-Patient Meals	148	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	453,119	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,447	19
20	Radiology and X-Ray	1,649	20
21	Other Medical Services	1,888	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 494,104	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc.	1,003	28
28a	Late Charges	5,597	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,600	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,382,866	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 740,809	31
32	Health Care	2,134,482	32
33	General Administration	1,357,348	33
B. Capital Expense			
34	Ownership	734,924	34
C. Ancillary Expense			
35	Special Cost Centers	593,675	35
36	Provider Participation Fee	65,880	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,627,118	40
41	Income before Income Taxes (line 30 minus line 40)**	755,748	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 755,748	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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